25th Anniversary

e

Linacre Quarterly

5 AUGUST, 1958 No. 3

A Journal of the Philosophy and Ethics of Medical Practice

OFFICIAL JOURNAL OF THE

Federation of Catholic Physicians' Guilds

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

(74 member Guilds)

President
WILLIAM J. EGAN, M.D.
1180 Beacon St.
Brookline 43, Mass.

First Vice-President
EUSEBIUS J. MURPHY, M.D.
3485 E. Tremont Ave.
Bronx 61, New York

Second Vice-President
J. E. HOLOUBEK, M.D.
1513 Line Ave.
Shreveport 39, La.

Third Vice-President
CLEMENT P. CUNNINGHAM, M.D.
414 Safety Bldg.
Rock Island, Ill.

Secretary
JOHN J. GRAFF, M.D.
1407 Woodlawn Ave.
Wilmington, Delaware

Treasurer
LESLIE D. CASSIDY, M.D.
4952 Maryland
St. Louis 8, Mo.

Moderator
RT. REV. MSGR. D. A. McGOWAN
1312 Massachusetts Ave., N.W.
Washington 5, D. C.

Executive Secretary
M. R. KNEIFL
1438 So. Grand Blvd.
St. Louis 4, Mo.

Editor, The Linacre Quarterly
REV. J. J. FLANAGAN, S.J.
1438 So. Grand Blvd.
St. Louis 4, Mo.

Honorary Presidents

NARCISSE F. THIBERGE, M.D.
846 Audubon Bldg.
New Orleans, La.

DANIEL A. MULVIHILL, M.D.
15 E. 77th St.
New York 21, New York

The Federation of Catholic Physicians' Guilds

The Linacre Quarterly

OFFICIAL JOURNAL

VOLUME 25 NUMBER 3

AUGUST, 1958

In this Issue . . . . .

THE LINACRE QUARTERLY is the official journal of the Federation of Catholic Physicians' Guilds and appears February, May, August, and November. Manuscripts and news items should be directed to the Editor. Correspondence concerning advertising, subscriptions and other business matters should be addressed to the Executive Secretary, M. R. Kneifl.

Regular subscription rate is $2.00 a year, or 50c for the individual issue. Remittances for subscriptions and other business transactions should be made payable to **THE LINACRE QUARTERLY.**

Subscriptions to **THE LINACRE QUARTERLY**, for members of the various affiliated Guilds defrayed from membership dues are arranged by the officers of the respective Guilds.

JOHN J. FLANAGAN, S.J.
Editor

MISS JEAN READ
Assistant Editor

EDITORIAL OFFICE:
1438 South Grand Blvd.
St. Louis 4, Missouri

Entered as Second Class Matter at the Post Office at St. Louis, Missouri.

President's Page

San Francisco was a most friendly city for the annual meeting of the Executive Board of The Federation of Catholic Physicians' Guilds. Severel high-lights of the day are worth noting here.

Oakland has a large and active Guild under the direction of a newly appointed and vigorous moderator, Rt. Rev. Msgr. William F. Reilly. From the report of their local activities, it is certain that their affiliation will add strength to the Federation.

San Francisco has a Guild that is hospital sponsored. As in all cases, the Guild is considered by those not on that particular staff as a hospital rather than a diocesan group. For this reason its diocesan activity in Catholic Action is, at least psychologically, limited.

The Sacramento Guild cooperated nobly. Its moderator, Rt. Rev. Msgr. Thomas H. Markham, was an excellent stand-in for our moderator and LINACRE QUARTERLY editor at the Executive Board meeting, the presence of the latter being required at the annual convention of The Catholic Hospital Association in Atlantic City. Drs. Wright and Frey manned the booth in Convention Hall the entire day, while your officers were busy at the Board meeting.

When His Excellency, Archbishop Mitty was notified of our presence, he sent his press representative to glean an objective report of our progress. That report was carried in the headlines and lead article of *The Register*, July 6. The N.C.W.C. News Service also carried the account.

The only spiritual activity listed in the A.M.A. Program of Events was the Memorial Mass at Notre Dame des Victoires Church. This convention of thousands of physicians, who act in imitation of and derive their faculties from their Creator, was devoid of any other acknowledgment of the spiritual.

The Executive Board had more Guild delegate representation than at any previous session.

The Educational Booth in Convention Hall evoked more interested inquiries regarding Catholic thought in medicine than the two previous displays. Not only was it well received by the non-Catholic visitors, but it served as an excellent focus of contact between your executive group and physicians from all dioceses in the country and abroad.

Perhaps the happiest memory of this meeting was the Wednesday afternoon gathering at the Sir Francis Drake Hotel. This replaced the conventional luncheon formerly held. What was projected as a reception for Catholic physicians attending the A.M.A. meeting turned out to be a wonderful "family party." Many of the delegates showed their interest in Catholic Action was a natural maturation of their family unity. They attended the convention with their wives and in some instances their entire families. To this reception they came *in toto*. The net result was that distance East to West and North to South was voided, as previous strangers became admirable friends in the common kinship of Catholicism.

WILLIAM J. EGAN, M.D.

The Economic Future ot Medical Practice

Leo C. Brown, S.J.

About the author: Father Brown is Professor of Economics and Director of the Institute of Social Order of St. Louis University. For the past seventeen years he has been on the faculty there and in addition to a professorship in economics has held various administrative posts in the University.

During World War II he was a public member of the War Labor Board and the National Wage Stabilization Board in the Seventh Region. During the Korean incident he was a member of that Wage Board in the Ninth Region. He is presently a member of the Atomic Energy Labor-Management Relations Panel and since 1942 has been engaged in arbitration of labor disputes throughout the Midwest. On occasion he has mediated a number of protracted labor disputes.

He received the A.B. degree in 1925, the A.M. in 1926, and the S.T.L. (a theological degree) in 1935, all from St. Louis University; and the Ph.D. in economics in 1940 from Harvard University. His writings include: ***Union Policies in the Leather Industry,*** *Harvard 1947;* ***Impact of the New Labor Law on Union Management Relations,*** *ISO, 1943; Chapters in* ***Social Orientations,*** *Loyola 1954, and occasional articles.*

Here follows an address Father Brown gave to the Catholic Physicians' Guild of Detroit, in March of this year.

ONE OF THE difficulties a layman experiences in discussing a matter of common interest with a professional group is the lack of a common language of discourse. The private practice of medicine may connote one thing to doctors and another thing to laymen. Logically we should begin this exposition with a definition of private medical practice but I doubt that I can readily frame a definition which would be wholly acceptable to all.

Some in the profession equate private practice with individual practice, some extend the concept to include many forms of group practice, others are tolerant of a wide variety of forms as long as the free choice of physician is preserved, while still others would defend as private any form of practice which preserves the patient's choice of doctor and the physician's freedom in the exercise of his professional responsibilities and in deciding the amount and method of compensation. It seems best, therefore, to forego definitions and discuss the organization of future medical practice as it may be affected by current economic trends.

In the past half century important changes have occurred in medical practice. Even 25 years ago great advances in the deterioration and treatment of illness had vastly affected the structure of medical practice. With the developments which had then been achieved in bacteriology, in serology and radiology, specialization had become an important part of medical practice and the apparatus for diagnosis and treatment of disease required the outlay of substantial sums of capital. In recent decades this trend has continued at an accelerated rate. Today no

individual can hope to be truly proficient in more than one or two of the specialized medical fields and few if any can hope to acquire all the equipment needed for complete diagnosis and treatment. As a result, there has been a growing interdependence of the general practitioner and the specialist and greater reliance of both upon the facilities of specialized clinics and hospitals.

These changes have inevitably been reflected in the organization of medical practice. A recent survey found that only 56 per cent of practicing physicians are engaged in individual practice. Another 11 per cent have expense or space sharing arrangements; two-man partnerships account for nine per cent; large partnerships and groups for seven per cent; salaried assistantships for three per cent and other salaried forms of practice in hospitals, in industry or government, in universities and in clinics operated by consumer groups for 14 per cent.[1] These estimates take no account of physicians in military service.

What evidence there is suggests that the trend away from solo practice will accelerate. Only one of four medical students opts for strictly individual practice. Thirty per cent of those in training, as contrasted to 16 per cent of doctors today, want to practice in a partnership or in a group organized by physicians.

There has, indeed, been a movement away from individual and into group practice; yet, if we look at the phenomenon in perspective, the shift has been remarkably slow. Twenty-six years have elapsed since the Committee on the Costs of Medical Care recommended that medical service should be furnished largely by groups of physicians and other associated personnel, organized preferably around a hospital, and rendering complete home, office and hospital care.[2] Today, however, there are about 800 formally-organized groups with 12,000 of the country's 220,000 physicians.[3] About one-sixth of the groups are organized on a prepaid, service basis.

Its advocates explain the slow development of large group practice by pointing to the traditional conservatism of doctors, to the problem of agreeing upon division of revenue and to the capital needed to set up facilities.

This conservatism may be overstated. Doctors who carry an inescapable and continuing burden of decisions affecting the health and lives of their fellow men are understandably conservative about methods of treatment. On the other hand, there seems small reason why this attitude should deter them from considering methods of practice which do not endanger — which, their proponents affirm, actually improve — medical care.

In any form of shared practice, the problem of dividing income is real but this is one area in which the medical profession can claim no monopoly. Among close friends

[1] Clifford F. Taylor, "Tomorrow's Doctor Won't Go It Alone," *Medical Economics*, September, 1957, p. 306.

[2] *Medical Care for the American People*, University of Chicago Press, 1932, p. 109.

[3] A. Deutsch, "Group Medicine," *Consumer Reports*, January, 1957, p. 37.

of mine in the legal profession one has been in two partnerships, another in three, in the past five years; the reason for the change in both cases has been the same — financial arrangements. This particular difficulty is probably outweighed by some of the advantages of group practice: the economy of shared space, better equipment and technical assistance and the ease of referral without risk of losing either the patient's confidence or custom.

The third reason offered for the reluctance to enter group practice — the initial costs involved — is, I suspect, the more important one. Many doctors, to whom this type of medical practice is attractive, lack the capital to establish the kind of facilities they regard as necessary or desirable. To the extent that initial cost has been an important obstacle to the growth of group practice, recent developments may alter the picture.

Experimentation in prepaid hospital and medical care on a large scale dates really only from the middle 1930s or early 1940s. The most important single factor in their development was the wage policy adopted by the government during World War II.

Insurance as fringe benefit

Wages were stabilized. With certain exceptions, employers could not grant wage increases which would put more money immediately in the pockets of employees. Non-inflationary fringe benefits were permitted, including pensions and health and welfare benefits. As one employer granted such benefits, others, competing in the tight labor market of those days, were forced to imitate him. And as one union successfully negotiated these benefits, other unions were forced to follow suit. The contract of the United Mine Workers in 1946 in which mine operators agreed to pay into a welfare and retirement fund five cents (now 40 cents) for every ton of coal mined, automatically set a standard for every union in mass production industries.

In 1948 the National Labor Relations Board in its famous Inland Steel decision held that pensions and a group insurance plan were "wages" and "conditions of employment" in the statutory sense and that employers were legally bound to bargain about them with the employees' bargaining agent, that is to say, with their union. In 1949 a Presidential Board of Inquiry in its report on a labor dispute in the steel industry concluded that

> industry . . . owes an obligation to the worker to provide for maintenance of the human body in the form of medical and similar benefits and full depreciation in the form of old-age retirement — in the same way as it does now for plant and machinery. This obligation is . . . one of the first charges before profits.[4]

These precedents and the pressures they put upon union representatives had by 1951 moved health and welfare benefits well toward the top of the priority lists in union negotiations.

The Korean War brought back wage stabilization. The Wage

[4] "Report to the President . . . on the Labor Dispute in the Basic Steel Industry." Washington, U.S. Government Printing Office, 1949. See also, "The Report of the President's Steel Industry Board," *Monthly Labor Review*, November, 1949, 69, p. 509.

Stabilization Board ruled, however, that inclusion of health and welfare benefits in labor agreements did not conflict with the government's policy of holding the line on wages. This ruling stimulated a rapid growth of health and welfare plans in union establishments with even nonunion establishments finding it either necessary or desirable to make similar provision for their employees. By 1952 unions, perhaps to their surprise (in some instances to their dismay), were solidly established in the health and welfare business.

Progress, however, in industry and by regions was uneven. Higher percentages of workers were covered by health insurance in manufacturing than in the service industries; coverage typically was higher in the middle West and middle Atlantic states than in the South and far West. In Detroit, for example, by 1952, 90 per cent of workers in manufacturing had some coverage, while the corresponding percentage in the service trades was 38. This may be compared with 46 per cent of workers covered in manufacturing and 19 per cent in services in New Orleans; and with 64.5 per cent in manufacturing and 58.4 per cent in services in San Francisco-Oakland in 1952.[5]

It should not be inferred that the 120 million-plus Americans or even a majority of them who now have some form of health insurance are members of unions; neither is it claimed that the unions were responsible for a major part of this development. What is significant is that the unions have a voice, in some instances the decisive voice, in the disposition of vast sums devoted to health coverage. How these funds are used may have an important effect upon the future organization of medical practice.

Perhaps a million workers and some of their dependents are covered by plans negotiated by the United Steel Workers; there is a similar number in plans in which the UAW has an effective interest. Last year the United Mine Workers fund spent $60 million in welfare funds. Even one local union in St. Louis, for example, representing employees in the lower wage brackets, has fostered a health program which presently has an annual budget of $1 million to provide comprehensive health care for 6,000 workers and about 8,000 dependents.[6]

Funds now are available to create well-equipped group-health clinics, if the unions decide that such is the better way to provide medical care.

In 1930 there was one consumer-sponsored health plan in the United States. Today there are scores of them, serving possibly more than 4 million people. The Health Insurance Plan of New York offers nearly comprehensive medical care to half a million people. The Kaiser Foundation with its ten hospitals, 25 clinics and 500

[5] U. S. Department of Labor, Bureau of Labor Statistics, *Wages and Related Benefits 40 Labor Markets 1951-52* (Bulletin No. 1113). Washington, U.S. Government Printing Office, 1952, p. 57.

[6] See A. H. Scheller, S.J., "How Co-op Health Plans Work," SOCIAL ORDER, 3 (October, 1953) pp. 357-61.

doctors offers similar care to about an equal number. The International Ladies Garment Workers' Union has health clinics in 14 cities offering preventive and diagnostic services and in some cases medical care to ambulatory patients. These centers are now available to 95 per cent of the union's 430,000 members. The AFL Medical Service Plan in Philadelphia services 33,000 union members and 22,000 dependents and has recently opened a clinic which will accommodate a population of 75,000. Other consumer-sponsored groups rely upon unions for much of the membership.

These are mentioned only as examples of the recent growth of consumer-sponsored health plans. In all, they represent but a small part of the vast program of prepaid medical care. They are significant when we realize that most of the growth of this type of plan has occurred since 1948.

Unions want preventive care. They want complete coverage. A typical insurance plan provides neither. Data presented in *Medical Economics* last year suggest that the patient among the 120 million Americans who carries some form of voluntary health insurance will pay about 10 per cent of his hospital bill and that one out of six will pay as much as 40 per cent; on average about 20 per cent of surgical expenses must be met by the patient, with one out of three paying as high as 40 per cent and one out of six as much as 60 per cent. Data on maternity cases are spotty but it is estimated that one out of three patients pay 20 per cent of the total medical expense. The typical patient paying as much as 40 per cent.[7]

Complaint of Fees

The most insistent complaint of administrators of union funds, however, relates to the size of the doctors' and surgeons' fees. There is a widespread feeling among such administrators that doctors, in judging patients' ability to pay, add to the insurance allowance approximately what they would have charged the patient had he not been insured. These officials have the impression that the doctors think that the insurance is not a cost to the patient but rather a donation from his employer and that the burden of carrying such insurance does not affect the patient's financial status. Such a judgment, the unions are quick to point out, is unsound. The employer's "contribution" to health and welfare has usually been won by the union at the cost of wage increases which were sacrificed.

The threat of the United Steel Workers to take its million members out of the Blue Shield program may be taken as an index of labor's feelings in these matters.

Mr. Walter Reuther's position is significant, not merely because he is head of the United Automobile Workers and of the Industrial Union Department of AFL-CIO, but because it reflects the thinking of a very large number of labor leaders. Reuther has been quoted as saying that the worker

[7] "Health Insurance Goal," *Medical Economics*, April, 1957, p. 90.

wants to know why, after paying his insurance premium, he has to pay out substantial amounts to the doctor when he has an operation; why he may have X-ray tests "only" when hospitalized; why so many medical services are not covered by insurance. The UAW president states that there is no longer a question about whether the worker is to have an adequate prepayment plan, but only how he is to get it. Reuther asserts:

> We cannot accept that quality is automatically lowered by any change at all in the prevailing pattern of practicing medicine and paying for it. . . . Unions will experiment with broadened prepayment and medical care organization.[8]

Speculating on these and other recent developments, Wallace Croatman last October raised the question, "Is Labor Through with Private Medicine?"[9] Nelson H. Cruikshank, the Director of the Department of Social Security, AFL-CIO, was quick to reply with an emphatic "no" in the same journal the following month. He added, however,

> . . . trade unions should be free to choose the type of program that best fits their needs, means and desires. We also believe that group-practice and direct-service programs should be among the choices available to them. Some [unions] prefer one plan; some prefer another. And they undoubtedly always will.[10]

It would appear that labor is determined not to sponsor in any wholesale fashion prepaid, direct-service medicine but to establish the right to experiment with such forms of medical organization. In taking this position unions came into head-on conflict with what appears to be the inalterable position of organized medicine. What is likely to be the outcome of such a conflict?

This is a question which needs to be seriously considered before any answer is attempted. There is a genuine possibility that if a conflict develops the medical profession may win the early engagements, with all of us, the medical profession and unions included, losing the war.

The sincere conviction of organized medicine in the soundness of its position and its undoubted strength in holding that position may blind it to the much larger risks involved. Skilled as doctors are in the arts of their profession they, as a group, show little adroitness in taking the public pulse.

The effectiveness of sanctions within the reach of organized medicine is best realized by members of the profession itself. A union-sponsored clinic, if it is to operate, must get doctors and the doctors must have hospital facilities. The medical director of such a clinic, a surgeon of considerable reputation, has told me of his experience in recruiting personnel. He has what he considers an adequate medical staff but he has not always been able to get the men he wanted. The young specialist who has passed his boards tells him frankly that he would welcome the opportunity of part-time assignment to the clinic, its assured income and the immediate

[8] "Reuther States His Case," *Medical Economics, November*, 1957, p. 173.
[9] *Medical Economics*, October, 1957, p. 174.
[10] *Medical Economics*, November, 1957, p. 48.

prospect of practicing his specialty; he also tells him with equal frankness that he "can't take the chance." If he did, he would not get referrals; he would endanger his hospital connections. He must, he explains, think not only of the next three but of the next 10 years. The possibility of expulsion from a county medical society is a powerful deterrent.

Struggle in Prospect

Organized medicine should recognize, however, that in a contest with unions it would meet an antagonist experienced in conflict, one with resources to carry contests to the courts, an adversary not devoid of influence with the public and with national legislatures.

The contest which is now going on between the director of the United Mine Workers Memorial Fund and some representatives of organized medicine might well suggest that unions will not easily relinquish a position which they feel compelled to take in the interests of their members. Another issue is involved in that controversy. Although originally permitting its beneficiaries to select any doctor of their choice, about a year ago the Fund removed some doctors and hospitals from its panel. Medical societies in Pennsylvania, Illinois and Colorado reacted promptly.

The Fund's version of the controversy is stated in an interview with Dr. Warren F. Draper, its medical director, early this year.[11] "We want," says Dr. Draper,

> to use the men best qualified to provide the care that our individual patients need. But organized medicine is taking a stand for free choice without a clear definition of the phrase. . . . The medical societies . . . are putting up a hard fight against our right to be selective.

He goes on to say that the medical plan was originally set up on a fee-for-service basis but that the Fund found that it was "tending toward subsidizing a gravy train." "In many communities," Dr. Draper continued,

> the surgical diagnosis and the operative surgery for Fund beneficiaries were clearly inferior in quality. And the amount of surgery performed was far in excess of what is performed on the general population.

Since unrestrained free choice did not work, the Fund wanted a system that would. It tried, said Dr. Draper, various plans. It tried to negotiate with medical societies in Pennsylvania without success.

When asked how the Fund would meet the opposition of medical societies, the U M W Fund's director replied that they were meeting it. In the Pittsburgh area the Fund dropped 200 doctors and 11 hospitals from their plan but have left 850 doctors and 17 hospitals for the members to choose from. Dr. Draper added that the vast majority of physicians who have worked with the Fund are satisfied with it. It may well be signficant that some county medical societies in Illinois quietly tabled the resolution of the State Medical Society about cooperation with the Fund. When we remember that the Fund spent about $60 million last year on medical care, we can anticipate that doctors, especially in com-

[11] Louis R. Chevalier, "Free Choice Has Failed," *Medical Economics*, January, 1958, p. 72.

munities where the Fund is an important source of much of the money spent for medical care, will not present a united front in any campaign which organized medicine directs against the Fund.

In Las Animas County, Colorado, the local society has taken punitive action against two physicians who disregarded its resolution and continued to cooperate with the Fund. They, in turn, have filed a suit in Colorado courts. The outcome of this action will be carefully watched by organized medicine, by unions and by large sectors of the general public.

One of the major problems faced by lay organizations, such as labor unions, who are interested in service-type medicine is the extent to which they can participate in organizing and directing groups which provide medical service. Both statute law and court decisions in many states are unfavorable to lay intervention in medical care. This fact in the past has permitted organized medicine to boycott such lay-sponsored groups with considerable success. There is evidence, however, that the courts are looking with greater favor upon such plans and are, as a result, scrutinizing boycotts against them by the organized medical profession.

In 1937 some federal employees in the District of Columbia organized the Group Health Association, a nonprofit prepaid medical care and hospitalization program offering service to government employees who met certain qualifications. The Association hired physicians on a salary basis to provide medical care for members and their families. The District Medical Society opposed this lay-sponsored group and expelled or otherwise disciplined some doctors who cooperated with it. Threat of expulsion from the medical society induced other doctors to withdraw from the association. Since Group Health Association had no hospital of its own, its staff had to rely upon hospitals in the community. The American Medical Association and the District Medical Society succeeded in persuading most of the hospitals in the District to deny their facilities to the Group Health Association staff. These actions led to criminal prosecution by the Justice Department under the Sherman Anti-Trust Act and in 1941 both the District Medical Society and the American Medical Association were found guilty of criminal conspiracy and in 1943 the Supreme Court of the United States refused to review the conviction.[12]

While this case is undoubtedly important as an indication of the attitude of federal courts toward systematic boycotts of lay-sponsored health plans, its value as precedent can easily be overestimated. Because the action took place in the District of Columbia, it was unnecessary to show that interstate commerce was involved in order to invoke the jurisdiction of the federal courts. Within one of the States, when the Sherman Act is invoked in an action alleg-

[12] *United States v. American Medical Association,* [130 F.2d 703 (D.C. Cir.), cert. denied, 310 U.S. 644 (1940)]. See also: *American Medical Association v. United States* [317 U.S. 519 (1943)].

ing boycott, it would be necessary to prove both that a conspiracy existed and that interstate commerce was affected. Medical practice by its nature is essentially intrastate and conspiracy is always difficult to establish. It is doubtful, therefore, that the Sherman Anti-Trust Act will play any large future role in medical cases.

Some of the state courts, however, have shown an indication to adopt attitudes similar to that shown by the federal courts in the Group Health Association case. In the contest between the Group Health Co-operative of Puget Sound and the King Company Medical Society, the Supreme Court of Washington stated:[13]

> . . . The [medical] society, in characterizing appellants' contract practice as "unethical," is making an unusual and arbitrary application of that opprobious term. It is not using the term as a label for conduct which is violative of some established moral principle applicable to the medical profession. Rather it here uses the term to castigate those who seek only to carry on contract practice independent of and in competition with Service Corporation. In our opinion, the Society may not, through the mere use of the term "unethical," clothe with immunity acts which would otherwise fall under the antimonopoly provisions of our constitution.

More recently, in 1952, in a case involving a county medical society and a local health plan, a California trial judge found that the prepaid program was not engaging in the illegal practice of medicine but, rather, was bringing patient and doctor together under an arrangement which offered medical care at reduced cost. The judge expressed the opinion that voluntary health plans are part of our times and may be "the answer to socialized medicine." "Some believe," he said, "that if we stop them we shall have to take the alternative, a system of state medicine financed through taxes."[14]

In 1955 the opinion of the attorney general of Minnesota was asked about the legality of chartering a nonprofit group to provide comprehensive, prepaid medical care. He distinguished two previous cases in his state which had held such groups illegal on the ground that these decisions dealt with profit-making associations. After examining decisions in related cases in other jurisdictions, he concluded that the consumer plan was concerned not with the professional but only with the economic aspects of medical practice.[15]

[13] *Group Health Cooperative of Puget Sound v. King County Medical Society,* [39 Wash. 2d 586, 603, 237 P.2d 737, 747 (1951)].

[14] *Complete Service Bureau v. San Diego County Med. Society,* [43 Cal. 2d 201, 272 P.2d 497 (1954)].

[15] "The objectionable features of the 'corporate practice of medicine,' or of any other profession, as stated by the Minnesota Supreme Court in the cases cited above, and by the numerous other courts that have considered the problem, are that the exploitation of the profession leads to abuses and that the employment of the doctor by a business corporation interposes a middleman between the doctor and the patient and interferes with the professional responsibility of the doctor to the patient. The corporation considered here would be non-profit and has a provision in its articles of incorporation prohibiting the corporation from intervening in the professional relationship between the doctors and the member-patients and confining the corporate activities to the economic aspects of medical and dental care. Therefore, a corporation so organized would not be subject to the objections urged against the business corporations that have been held prohibited from entering this field." (Unpublished opinion, Oct. 5, 1955.)

Despite what appears to be a more favorable trend in judicial opinion to the lay-sponsored health plans, the fact remains that union and consumer groups still find that the law is a major obstacle to the organization of prepaid medical care plans. In varying degrees statutes in many states restrict the operation of such plans to those with medical society approval or control. Some statutes require that a majority of the directors be doctors, others provide for medical society approval of directors, others bar a prepayment plan unless it includes the majority of the licensed physicians in an area. Such statutes are almost insurmountable hurdles for lay sponsors who want to organize a prepaid comprehensive plan.[16]

The American people, however, is determined that all its constituent groups shall have health care at a cost they can afford. There is a growing conviction that prepaid service-type medicine will afford that care at a cost within their reach. If experimentation with such plans becomes a matter of public controversy, an aroused public opinion, stimulated by organized groups including but not confined to labor unions, may lead to legislation at the national level which would modify the structure of medical practice in even more drastic ways. If, however, experimentation is permitted, the verdict on prepaid, comprehensive-type medical service will be rendered by experience; the deciding factors, moreover, will be the quality of care, the satisfaction of patient and doctor and relative cost.

Is consumer-type medicine inferior? A study of the Labor Health Institute of St. Louis, Missouri, made in 1954 by Dr. Franz Goldman, M.D., Associate Professor Medical Care, Harvard University School of Public Health, and Evarts A. Graham, M.D., Bixby Professor of Surgery Emeritus, Washington University, St. Louis, Chairman of the Board of Regents, American College of Surgeons, said:

> In volume and direction the medical service, diagnostic tests, and hospital services received by the group met high standards. . . . The record . . . is all the more impressive as the group eligible for service consists of individuals and families earning less than $3,000 a year in the great majority of all cases. As apparent experience shows, people in this income-group usually obtain only a fraction of those services which the L.H.I. provides routinely.

In its summary the report quotes a comment made by one of the physicians of the regular staff, "I wish I could practice as good medicine in my own office as I can here."

Regarding the compensation of physicians, the report stated:

> . . . An internist who serves 12 hours a week at the medical center, makes the necessary visits to hospitalized patients, and takes care of home calls can count on an annual net income of at least $6,700. A pediatrician who has a schedule of 5½ hours of service a week at the medical center, visits children, mainly newborn, in the hospital and answers home calls earns approximately $5,300 net per year. A surgeon who spends six hours a week on service to patients at the medical center, performs an average of eighty operations in the hospital during a year, and discharges administrative functions at

[16] See "The American Medical Association: Power, Purpose, and the Policies in Organized Medicine," *Yale Law Review*, 63 (May, 1954) p. 993.

L.H.I. has a net income of approximately $7,200 per year.

It is hard to imagine criticism of these net incomes on the grounds of inadequacy or unfairness.[17]

Experience of the H.I.P. in New York and to a lesser degree with L.H.I. in St. Louis has revealed some dissatisfaction on the part of patients. The experience of both plans, it should be remembered, has been comparatively brief. The evidence of the Goldman-Graham reports suggests that these plans may render a quality of service which recipients in the lower-income groups could otherwise not afford; further experimentation might evolve arrangements which will eliminate the basis for most dissatisfaction on the part of patients.

A very fundamental issue is the cost of such plans. These programs are not cheap medicine. They were launched during a period of prosperity unequaled in our history. The budget of the L.H.I., for example, is more than $1 million a year. It has yet to be demonstrated that year-in-and-year-out, in good times and bad, a low-income group of 6,000 workers can afford such an outlay. These basic issues must be settled by experience and experimentation.

Costs rising

Public interest in the cost of medical care will become more alert in the future because the cost of such care is rapidly mounting. Associated Hospital Service of New York, which administers the Blue Cross Plan in the New York metropolitan area, recently presented a public hearing for a 40 per cent increase in its rates.[18] Insurance companies handling group hospital insurance have been increasing their premiums. Mr. Walter M. Foody, Assistant Vice-President of the Continental Casualty Company of Chicago, was quoted last fall as saying:[19]

> Many of our group policies, maybe half of them, have gone up an average of five per cent a year over the past two years. Some increased as much as 20 to 30 per cent.

This increase in hospital rates reflects in part greater utilization of the hospitals by doctors and patients. It reflects also the fact that many of the programs pay sickness benefits only when the patient is hospitalized, thus assuring increased use of hospitals during sickness. But a major part of the increased premium reflects the rapidly mounting costs of labor and equipment in the hospitals. Nonprofit hospitals in 1946 reported an average cost of $10.04 per day. By 1956 the cost more than doubled and is expected to go higher. More frequent use of expensive drugs and equipment adds further to the cost. Doctor bills, too, will probably increase on average. It is unreasonable to expect that physicians will be satisfied with static incomes in a period of inflationary trends.

Other very real problems of medical care will get increasing attention from the public. People are living longer and the older

[17] These data on physician income relate to 1954. The writer has been informed by one of the participating physicians that the amounts should be increased by approximately $1000 each to make them current.

[18] *Wall Street Journal*, November 22, 1957.

[19] *Ibid.*

they get the more pressing become their medical needs; yet few of these older people are in position to pay large hospital and medical bills. Many people in these age groups are not insurable, or insurable only at very high rates. All of these problems will increase pressure for federal interest and federal aid in medical care.

Rapidly changing medical techniques, rising costs of medical care and the increasing demand that more medical care be made available to all segments of the public will undoubtedly promote further experimentation with forms of medical practice. The real threat to the physicians' independence is not prepaid service-type medicine. Rather, it is that private groups who are currently sponsoring such programs may yield to the temptation of thrusting the burden on government. To the layman the questions involved in such programs are essentially issues not of medical ethics, but of medical economics. Only by meeting these questions in terms of the real issues can organized medicine contribute to their solution. By assuming leadership in experiments with new and unproved systems of practice and payment organized medicine can best insure preservation of the profession's essential interests and independence.

Reprinted from ***Social Order,*** *June, 1958 issue, with kind permission of the Editor.*

Progestational Steroids: Some Moral Problems

John J. Lynch, S.J.

Professor of Moral Theology

WESTON COLLEGE, WESTON, MASS.

EDITOR'S NOTE. Physicians now have at their disposal certain new drugs which apparently are proving effective in the correction of various gynecological disorders. But because these drugs can also inhibit ovulation and consequently produce a state of sterility until withdrawn, some of our doctors have raised the question of the licitness of prescribing them for their patients. Accordingly we have asked Father Lynch to comment on the drugs in question from the moralist's point of view.

SOME SIX years ago Dr. Benjamin Sieve claimed rather spectacular success with phosphorylated hesperidin as an oral contraceptive agent.[1] Taken each day in tablet form and in specified quantities, this compound would allegedly after ten days produce a state of sterility which would then last as long as the medication was continued, and which could be reversed simply by discontinuing the drug. The sterilizing effect was reportedly achieved by creating a viscous barrier around the ovum, making it immune to the penetrating properties of spermatozoa. After experiments conducted on some three hundred couples, Dr. Sieve claimed 100% effectiveness for his oral contraceptive, and also maintained that two hundred and twenty of the wives involved conceived within three months after discontinuing the medication.

Whether or not the claims made by Dr. Sieve are scientifically sound, the method he proposed is at least in theory typical of one possible form of physiologic fertility control, viz., a medication whose *one and only* purpose would be to induce a temporary state of sterility for patently contraceptive reasons. With regard to this generic type of fertility control there can be no doubt in the moral order: since the one and only immediate effect of such medication would be temporary sterility, its use would necessarily be condemned as an illicit form of sterilization, in accordance with the teaching of the Church that *direct* sterilization of man or woman, whether perpetual or temporary, is forbidden by natural law. Furthermore, since the only conceivable reason for taking such medication would be to prevent conception by disrupting the natural post-coital processes, the practice would also assume the malice of onanism, and would consequently

[1] "A New Antifertility Factor," *Science* 116 (Oct. 10, 1952) 373-85.

be a violation not only of the Fifth Commandment but also of the Sixth. The same must be said of any form of physiologic fertility control whose one and only effect would be to induce sterility.[2]

MORE RECENT DEVELOPMENTS

In more recent years, however, attention has been focused on the progestational steroids which likewise are capable of inducing sterility by inhibiting ovulation. But as antifertility factors these compounds are both medically and theologically distinct from the previous type insofar as they are of their nature calculated to produce not only the effect of temporary sterility but also other immediate effects which in themselves are the legitimate objects of direct intent, e.g., the correction of certain menstrual disorders. Consequently the moral question which immediately arises is this: would the use of these drugs in some circumstances admit of legitimate application of the principle of double effect?[3] In other words, are there practical medical situations in which their use for a legitimate purpose could be justified, even though temporary sterility would also be necessarily but unintentionally induced?

Before answering that question, a moralist perhaps should be more specific as to his understanding of the nature and function of the drugs in question, which already can be identified by various trade names according as one or another pharmaceutical house has produced its own version. Enovid, the product of G. D. Searle & Co. can best serve as an example, since authoritative reports on the use of this compound appear to be the most abundant of any.[4]

Enovid is a synthesized steroid which exercises progestational activity within the reproductive system. One gathers, in other words, that these synthetic hormones produce artificially many of the effects which would be caused naturally by the hormonal balance which is characteristic of the period of pregnancy. One of those effects provided for by nature dur-

[2] For a more detailed moral appraisal of Dr. Sieve's method of fertility control, cf. J. J. Lynch, S.J., "Fertility Control and the Moral Law." LINACRE QUARTERLY 20 (Aug., 1953) 83-88, and "Another Moral Aspect of Fertility Control," *ibid.* (Nov., 1953) 118-22.

[3] In the first of the two articles cited in the previous footnote, this conclusion will be found (p. 87) regarding phosphorylated hesperidin as an antifertility factor: ". . . in the light of currently available data regarding proposed methods of fertility control, it is simply impossible to justify their use as an instance of double effect. There just is no second effect involved. The sole intrinsic purpose . . . of such therapy is contraceptive, and no other direct effect, which could be admitted as licit, has yet been seriously alleged. If . . . physicians should ever discover any genuine therapeutic value that would constitute a legitimate second result directly imputable to antifertility pills or serums, then that will be the time to consider the possibility of indirect sterilization." Since the drugs now in question do supposedly admit of a legitimate therapeutic use, recourse here to the principle of double effect does not represent a change in principle but rather a change in the medical facts of the case.

[4] My information regarding Enovid is taken for the most part from *Proceedings of a Symposium on 19-Nor Progestational Steroids* (Chicago: Searle Research Laboratories, 1957) and from the same company's reference manual No. 67, *Enovid*. The *Proceedings* of a second conference on the same topic, held in New York some months later, should be obtainable from Searle by the time this article appears in print.

ing gestation is the suppression of ovulation in the expectant mother. Without further ovulation, obviously, there can be no further conception. Once pregnancy is terminated, hormonal activity reverts to the predominantly estrogenic, ovulation resumes, and conception is again possible. These synthetic hormones, therefore, can produce in the non-pregnant woman the same contraceptive effect which nature itself provides during actual gestation.

CONTRACEPTIVE USE

When used designedly for contraceptive purposes,[5] the Enovid regimen is begun five days after the onset of menstruation and a prescribed dosage is taken daily for twenty consecutive days. Medication is then interrupted to allow the next menstruation to take place, and bleeding usually occurs within two or three days after withdrawal. This 20-day cycle of medication is then repeated over as long a period as conception remains undesirable. Fertility may be restored simply by discontinuing the treatment. And the Puerto Rico experiment with Enovid, begun in early 1956, has provided some amount of evidence favoring the effectiveness of this type of drug as a contraceptive agent. This is Dr. Edris Rice-Wray's own résumé of a report which he submitted in January, 1957:

> Two hundred and twenty-one mothers of less than 40 years of age, living in a slum clearance area in Puerto Rico, have been on Enovid for one month to nine months. Adding the time on the medication of those who were on it three months or more, there was a total of forty-six patient years. There were no method failures. There were seventeen patient failures because they dropped the medication; eight of these had reactions.
>
> Seventeen per cent of the patients had reactions. Twenty-five patients withdrew from the study because of reactions. The most typical complaint was dizziness, nausea and headache.[6]

Dr. Rice-Wray's conclusion: "Enovid gives 100 per cent protection against pregnancy in 10-mg. doses taken for twenty days of each month. However, it causes too many side reactions to be acceptable generally."[7]

Over and above these immediate side effects — which eventually perhaps can be eliminated — the long-term reactions to drugs such as these, if used continually over a long period of time, is a problem yet to be faced. One gets the impression that many doctors are frankly fearful of what nature's penalty may be for tampering in this way with so delicate a mechanism as the human reproductive system. Another incidental but very practical problem is that of expense. At present, for example, one month's supply of Enovid would cost eleven dollars. But to a limited extent the oral contraceptive seems to be already a reality of sorts, although it may be a long time, if ever, before these products will be sold over the counter without a doctor's prescription.

It should be altogether clear that if progestational compounds are employed designedly in order to prevent conception, their use is contrary to moral law. As ex-

[5] Cf. Edris Rice-Wray, M.D., "Field Study with Enovid as a Contraceptive Agent," *Proceedings etc.*, pp. 78-85.

[6] *Art. cit.*, p. 85.

[7] *Ibid.*

pressed in no. 33 of the *Ethical and Religious Directives for Catholic Hospitals:*

> **All operations, treatments, and devices designed to render conception impossible are morally objectionable. Advising or otherwise encouraging contraceptive practices is not permitted.**

From the moralist's viewpoint there is no essential difference between a medication whose one and only effect is contraceptive and a medication whose effects may be plural but which is employed with the direct intention of producing its contraceptive result.

LEGITIMATE USES

However, the majority of doctors who are currently making use of Enovid and allied products are prescribing them for purposes which are entirely legitimate. These drugs, for example, have apparently proven remarkably effective, after several months' treatment, in the control or correction of certain serious menstrual disorders. Amenorrhea, metrorrhagia and menorrhagia, oligomenorrhea, dysmenorrhea, premenstrual tension — all have reportedly been successfully treated with the progestational steroids. Another feature attributed to Enovid is its potential as a positive aid to fertility. In some cases, for instance, with women whose cycles had previously been anovulatory, ovulation was stimulated after several months of treatment and conception thereby made possible. Finally, in a limited number of infertile women with a history of normal ovulation, the so-called "ovulation rebound" has been observed. Over a period of several months ovulation was totally suppressed. The medication was then withdrawn and within a few months a significant number of these previously infertile women had achieved pregnancy.

Beyond any doubt these effects are legitimate objects of one's direct intention. The only question which remains is this: is one justified in achieving such effects by means of medication which is also antiovulant?

In a number of cases in which Enovid would be prescribed, there would appear to be no moral problem whatsoever, since the medication is taken only at such times during the cycle as would still permit ovulation. Thus, for example, in the treatment of premenstrual tension and inadequate luteal phase, the recommended dosage is begun on day fifteen of the menstrual cycle and terminated on day twenty-five.[8] On this regimen ovulation will normally have occurred in each cycle before medication is resumed. Since in these cases there is no question of inducing even temporary sterility, no moral reason can be advanced against this particular cycle of medication when medically indicated.

But when dealing with certain other disturbances of menstruation, a 20-day regimen — from day five to day twenty-five — is apparently considered either necessary or preferable,[9] and in these cases ovulation will be made impossible. In order to determine the licitness of using Enovid and similar products

[8] Searle & Co., *Enovid,* p. 16.

[9] *Ibid.,* pp. 13-16 passim.

in these latter instances, the principle of double effect must be applied. That principle, as it pertains generally to procedures which induce sterility is aptly expressed in no. 31 of the *Directives:*

> **Procedures that induce sterility, whether permanent or temporary, are permitted when:**
>
> **a) they are immediately directed to the cure, diminution, or prevention of a serious pathological condition;**
>
> **b) a simpler treatment is not reasonably available; and**
>
> **c) the sterility itself is an unintended and, in the circumstances, an unavoidable effect.**

If these three conditions are fulfilled in a given case, neither the doctor nor the patient need hesitate to make use of Enovid or similar compounds. If any one of the conditions cannot be verified, the induction of even temporary sterility would be morally unjustified.

PRACTICAL RULES

Perhaps the following questions would prove helpful for determining in particular instances whether these requisite conditions for legitimate recourse to the principle of double effect are fulfilled. The doctor's honest answer to each of these questions will provide the basis for a sound moral decision.

a) "According to sound medical judgment, is my patient suffering from some pathological condition sufficiently serious to warrant the use of this medication?" Beyond question there can be and are menstrual disorders which qualify as seriously pathological in the sense that they involve considerable pain, discomfort, disability, or other inconvenience for the patient. "Serious" in this context certainly does not mean that any danger of death need be involved. It suffices that the patient's ailment be of such a nature that competent medical judgment would conclude that relief is advisable even at the cost of temporary loss of the reproductive function. Some menstrual disorders are such as to justify even hysterectomy and consequent irreversible sterility.[10] Far less serious pathology would be required to justify temporary sterility as the indirect result of a procedure immediately directed to relief from pain or from some other considerable inconvenience. The medically honest doctor who prescribes Enovid or similar drugs *only as medically indicated* for disturbances of menstruation will not go wrong as far as this first condition is concerned.

b) "Is there conveniently available any simpler treatment which would be satisfactorily effective in correcting this condition?" By "simpler" treatment in this context is meant principally one which would not result in even temporary sterility. If such a medication were reasonably available and would be satisfactorily effective, there would be no necessity — and hence no justification — for employing a procedure which results in temporary sterility. Thus, for example, if a particular ailment would submit to Enovid administered on the 10-day regimen (i.e., from day fifteen to day twenty-five

[10] Cf. Gerald Kelly, S.J., *Medico-Moral Problems* (1958 edition) pp. 206-217; or Vol. I of the original 5-booklet edition, pp. 30-34. (For details of the 1-volume revision of Fr. Kelly's work, see advertisement in this issue of LINACRE QUARTERLY.)

of the menstrual cycle), there would be no adequate reason to prescribe the medication on the monthly 20-day schedule which inhibits ovulation.[11] However, if the physician sincerely judges that only the longer cycle of medication will prove effective, he need not hesitate to prescribe it after explaining to his patient that temporary sterility will be one of the side effects of this treatment. It need scarcely be said that medication should not be continued longer than is necessary to correct the pathology for which it was begun. Nor should it be continued after it has proven certainly ineffective as a remedy or control in unresponsive cases.

c) "Can I honestly say that contraception is excluded from my intention when prescribing this medication?" When dealing with genuine menstrual disorders, the sincere and conscientious doctor should have no difficulty in answering this question in the affirmative. In fact, if he has given himself honest answers to the first two questions, there is hardly need to propose this one. Provided that he is intent on relieving some truly pathological condition for which no simpler remedy is available, it is not likely that this third condition would prove a hazard to the doctor of principle.

"OVULATION REBOUND"

One further doubt remains to be solved: if the alleged "ovulation rebound" phenomenon is a scientific reality, would the use of Enovid for this purpose present any difficulty? For it would appear that fertility in this case is achieved by first suppressing ovulation as a means to a further end, and that consequently the suppression of this function is directly intended.

It is not as yet certain that all theologians would agree on the ultimate answer to this question. Only subsequent theological discussion will reveal what differences of opinion there may be. But there would seem to be valid reason for suggesting that the use of Enovid in this way does not contravene the prohibition against direct sterilization.

First, it should be noted that it is not precisely the direct suppression of ovulation which is forbidden as intrinsically wrong, but rather is it the resultant sterility, or inability to procreate, which may not be the direct object of one's intention. That the two are not entirely identical is clear, for example, in the case of a woman who has already undergone hysterectomy. Ovariectomy, if subsequently performed on this woman, surely could not be called sterilization in any proper sense of the word. So, too, in cases where ovulation rebound might be attempted in the infertile woman. Would it not be totally unreal to speak of

[11] Under the heading "Clinical Applications and Dosages," the Searle manual *Enovid* (pp. 13-16) several times uses this type of direction: "Such patients should receive one tablet daily from the fifth or from the fifteenth to the twenty-fifth day, depending on the importance of maintaining ovulation in individual patients." Since this statement as it stands is morally ambiguous, I can only repeat that if the shorter cycle of medication is effective as a remedy, it must be chosen in preference to the 20-day regimen. Otherwise one would equivalently be directly intending sterility.

sterilizing a person who for all practical purposes has proven herself to be already sterile, i.e., incapable of conceiving? Chiefly for this reason I would venture the opinion that for purposes of solving infertility problems the use of Enovid to induce ovulation rebound is morally above reproach.[12]

[12] One gynecologist, who was kind enough to read this article in typescript, offered this comment: "I also wonder 'if the alleged "ovulation rebound" phenomenon is a scientific reality.' I would be inclined to believe that the patients who conceived after Enovid therapy did so because undiagnosed endometriosis (which is a notable cause of infertility) was controlled by the therapy, allowing prenancy to occur after the withdrawal of the drug." If the doctor's suspicion should prove correct, these cases present no special moral problem, for medication could then be directed to the control of endometriosis, while the suppression of ovulation could qualify as an incidental side effect of therapy.

The Impediment of Impotency and The Condition of Male Impotence

A Canonical-Medical Study

Rev. Paul V. Harrington, J.C.L. and Charles J. E. Kickham, M.D,. F.A.C.S.

Editor's Note: The study which follows was prepared at the request of His Excellency, Eric F. MacKenzie, Auxiliary Bishop of Boston, with his following remarks to precede the presentation:

The Linacre Quarterly is read chiefly by physicians and priests. The article which follows has two authors, one a priest and the other a physician. Each has his problem: the priest to write about Church law in terms that will be understood by physicians, and the physician to write in terms that will be understood by priests.

Impotency in relation to the validity of marriage is a highly specialized problem both in law and in medicine. In my judgment it is interesting and useful to put together in one treatise an authoritative statement of what is known in both disciplines.

May I, as a priest, address a preliminary word to the physicians? As you read Father Harrington's article, you may well be surprised to learn that there are two schools of thought which are quite opposed, yet each supported by leading theologians and canonists. We priests know and expect this to be true in many problems of faith and morals. You. on the other hand, may have expected that a prompt and definitive answer would be forthcoming for every problem that arises. The Church does not act with that immediate promptness. She waits, looks for information that is more and more complete, invites study and writing and comment by competent students, and only at long last, under the guidance of the Holy Spirit, announces a formal and final decision.

This treatise will do its part in the process of study and evaluation. Hence, I commend it to both priests and physicians. I trust it will have many interested readers.

PART I

CANONICAL CONSIDERATIONS

The purpose of this article is to set forth the legal definition of impotency, the constitution of the canonical impediment of impotency, a description of an impotent condition and finally a consideration of the various anatomical and physiological findings that bear on male impotency.

Since this article is primarily concerned with impotency, as a canonical impediment to marriage, which can prohibit a contemplated marriage from taking place or can invalidate a marriage that has already been contracted, the canonical definition of impotency is the one that will be considered and not the medical definition, as it is pos-

Father Harrington received the degree of Canon Law at Catholic University of America. He has been Vice-Officialis of the Tribunal of the Diocese of Burlington, Vermont and Defender of the Board of the Tribunal of the Archdiocese of Boston. At Newton College of the Sacred Heart he is Professor of Sacred Theology. In addition to lecturing on Medico-Moral-Legal subjects, Father Harrington is also Director of Pre-Cana Conferences in the Archdiocese of Boston.

sible and probable for a divergence to exist between the two.

It is the privileged prerogative of God Himself, through the media of Divine Natural and Positive Law and the Supreme Pontiff, through the channels of Ecclesiastical Law, to establish impediments to christian marriage, which will affect its validity or nullity. It is the role of the canonist to consider these statutes, define them, study their gravity and extent, be prepared to apply the norms to general and specific cases and to make judgments as to the presence or absence of a given impediment in an individual instance.

When an impediment is based on anatomical findings or physiological data, the canonist will enlist the help and assistance of trained medical specialists, accept their diagnosis and prognosis and then proceed to a conclusion, which will, at all times, be guided by canonical definitions and legal jurisprudence as applied to the medical findings and not necessarily by the medical judgments themselves, since the question of deciding the presence or absence of a diriment impediment and of passing on the validity or nullity of a particular marriage is basically a juridical matter and only secondarily involves medical opinion.

The reference to impotency in the Code of Canon Law is very brief, simple and direct and, to all appearances, would give the impression that the entire matter was very clear, provided no difficulties or problems and gave rise to no controversies. However, beneath and in back of the rather innocent wording of the statute lies a long history of conceptual and notional evolution, which has included many difficulties, divergent opinions and contradictory statements. Obviously, this particular presentation must of its nature be brief and only a summary of the legal developments can be presented.

Canon 1068 of the Code of Canon Law, in two sections, contains the only reference to the impediment of impotency. It states: "Antecedent and permanent impotency, whether on the part of the man or on the part of the woman, whether known to the other party or not, whether absolute or relative, invalidates a marriage by natural law. If the impediment of impotency is doubtful, whether the doubt be one of law or of fact, a marriage is not to be prohibited." A third section of this statute, while it does not treat specifically of the impediment of impotency, does differentiate between impotency and sterility and indicates that sterility alone does not prohibit or invalidate a marriage.

The earliest legal documents, concerning impotency, that are now available to the research student are contained in the Decree of Gratian which was compiled in the twelfth century to bring together in one place all of the statutes on multitudinous subjects that formed the body of the law of that time.

No clear, definite and distinct conclusion can be drawn from the Decree of Gratian as to whether

impotency constituted an invalidating impediment or merely could be urged as a canonical reason for the dissolution of a marriage that could not be properly consummated. The reason for this lack of clarity is the fact that, at that time, there was raging in canonical and theological circles a lively discussion between the proponents of the consensual theory and the advocates of the copular theory. The former were of the opinion that the consent alone of the parties was sufficient to bring a marriage into existence; while the latter group insisted that, in addition to mutual consent, proper consummation of the union was required before a perfect marriage was had.

Thus, those who favored the consensual theory would consider impotency to be an impediment; whereas the supporters of the copular theory, which required consummation, would look upon impotency as a canonical reason for dissolving an unconsummated marriage.

The Decree of Gratian did distinguish antecedent and subsequent impotency, between absolute and relative impotency but there is no clear reference to a distinction between temporary and permanent impotency.

The Law of Gratian did introduce an unusual distinction between natural impotency, which arose from some irregular condition within the person himself, and impotency, which had its basis in the workings of the devil, magic, sorcery or witchcraft and thus was always caused by some external agent. This latter category did furnish much interesting discussion in the canonical and theological literature from the eighteenth century and most authors considered such an impotency to be a punishment, sent by God for past misdeeds, and, as such, would affect only the specific couple and, in many instances, could be cured by spiritual remedies — a general confession of all sins, exorcisms, fastings, prayers and offerings, which would help to placate the offended God.

The next great compilation of law was the Decretals of Pope Gregory IX, which appeared in the thirteenth century and consisted mainly of letters from various Popes to Bishops of varying dioceses. These letters contained answers, legal interpretations and decisions with respect to problems that had originally been referred to the Holy See for solution.

In studying the decretal letters referring to impotency, there can be no doubt that, at this particular time, an impotent condition was considered to constitute an invalidating impediment that would nullify a marriage that had been contracted. The canonists, who wrote commentaries on the decretal legislation, unanimously agreed that impotency constituted a diriment impediment.

However, both the decretal legislation and the legal commentaries insisted that before an impotent condition would in fact constitute the nullifying impediment, it would have to be proved that the impotency actually existed

at the time the marriage was contracted and was therefore antecedent and also that the condition was incurable and was, therefore, permanent. The impotency could be absolute in the sense that it rendered marital relations impossible with every member of the other sex or merely relative in that it prevented sexual intercourse with a definite person or specific individuals. The condition could spring from a natural cause within the individual or could arise from an accidental cause involving some external agent.

St. Thomas Aquinas injected the note that if the impotent condition were known before the marriage, at least by the healthy party, and marriage was nevertheless contracted, the condition did not constitute an impediment, even if it were permanent and the marriage would be recognized as valid. This theory was not acceptable to many canonists or theologians and very quickly disappeared from the literature.

The reason that St. Thomas' opinion did not receive the approbation of more authorities was because, in the thirteenth century, the contractual notion of marriage was being developed and was evolving. With marriage being considered as a contract, it was evident that the contracting parties assumed definite duties, responsibilities and obligations, which they were expected to fulfill. The object of the marital contract was judged to be the transferring to one's spouse of rights over one's own body, which rights were to be exercised in the performance of those acts which would provide for the generation of children and the acceptance of the rights that were transferred by one's spouse. This object of the marital contract would provide for the attainment of the purpose of marriage, which was known to be the procreation of offspring.

In the light of this new development, an impotent person could not be considered capable of transferring to anyone else rights over his body for the performance of the marriage relation because that body was incapable of participating in true sexual intercourse. In effect, the individual could not give what he did not have. Thus, an impotent person was thought incapable of assuming obligations which he could not fulfiill and it was for this precise reason that impotency was believed to constitute a diriment impediment to marriage.

It is obvious that mere knowledge of an impotent condition and acceptance of it by the healthy individual could not in any way alter the situation and render the impotent person capable not only of assuming but of fulfilling the contractual obligations of marriage and thereby attaining to the purpose of marriage. Since this was considered impossible, the theory of St. Thomas fell into disrepute and was rejected by most canonists and theologians.

From the thirteenth century up to the present day, there has been no change in the doctrine that impotency, with its proper qualifiers, constitutes a diriment impediment, which will forbid a

contemplated marriage from taking place and will invalidate a marriage, which has already been contracted. The only one addition to this law is the important reference in the Bull, *Cum Frequenter*, which was issued by Pope Sixtus V on June 27, 1587, that the invalidating impediment of impotency comes directly from divine natural law and not merely from an ecclesiastical statute. The importance of this added note is that no dispensation can ever be granted and also that the impediment binds all persons of whatever religion or creed, whether baptized or not.

This understanding of impotency is accepted by all canonists and theologians at the present time and has been accepted by them since the thirteenth century. This is one matter in which there is and has been universal and unanimous agreement, without any controversy.

A brief explanation of antecedence and permanence might be beneficial at this time.

There is no difficulty in proving the antecedence of the impotent condition, if it arises from a congenital cause or from a surgical intervention or accident, which occurred before the marriage. There were authors who thought that if the antecedence of the impotency was not definitely proved and remained in doubt, the condition was to be presumed antecedent but this opinion is no longer acceptable, since every marriage is to be presumed valid until the contrary has been proved by convincing evidence and if any doubt remains after an exhaustive and complete investigation, the doubt is to be resolved in favor of the validity of the marriage and the subsequence of the condition.

If medical science has not discovered a cure for a particular condition that causes impotency, then, there is no question that the condition is permanent. If there exists a known cure but this therapy requires the intervention of a miracle or the use of illicit and sinful means or the treatment is dangerous to the body of the patient and entails a danger of death, then the impotent condition is to be judged as permanent. However, if a natural remedy is at hand, which is licit and in no way involves a danger to life, but the afflicted person refuses to avail himself of it, the impotency is to be adjudged temporary, even though the condition is, in fact, never ameliorated because a cure is available and the patient has the obligation of taking advantage of it and of rendering himself potent.

Again, if a doubt remains as to the possibility or probability of a cure or a doubt arises as to whether a particular and specific remedy approximates a miracle or entails a danger to the life of the individual or might be illicit and sinful and this doubt cannot be resolved, the condition is to be presumed temporary, the marriage is not to be prohibited and, if it has already been contracted, it is to be considered valid.

It is evident from the above that the temporary or permanent nature of an impotent condition depends

on the advances of medical science. Thus, a condition which is considered to be permanent today, because no cure or remedy is known or because the known cure is not natural, is illicit and sinful or because the remedy entails a danger to the life of the individual, may well become temporary in the future, as the development of modern medicine uncovers new procedures as it conquers new horizons.

From the thirteenth to the sixteenth century, potency was considered to be the ability to become one flesh with one's spouse and thereby to be able to consummate a marriage. In general, it was necessary and essential for a man to be moved by a desire for sexual intercourse, that he have a male organ which was erectible and which was proportionately apt for the penetration of his wife's body, that he be able to emit and deposit semen within the vagina. It would appear that if any of these elements or any combination of them or all of them were lacking or deficient or any of the organs were otherwise atrophied or paralyzed, a condition of impotence would be considered to exist.

In the canonical and theological literature of this particular period, no specific diseases or medical anomalies or abnormalties were mentioned as constituting an impotent condition. The reason most probably is that the study of anatomy, physiology and endocrinology had not evolved much by the sixteenth century.

It will be the burden of the ensuing pages to discuss the *condition* of impotency from the time of the Council of Trent in the 16th century up to the present time. This section will be of practical interest to the theologians, canonists and the medical profession because the particular cases, with which they will be associated, will ultimately be resolved by the application of the legal interpretation currently in vogue and not by the understanding of past centuries, although reference to the prior opinions has been and will be necessary to show the development and evolution of the various concepts, to lay the ground work for the modern principles and to demonstrate that the growth, from the beginning up to the present day, a span of some 800 years, has been rather stormy and turbulent.

The most important document, bearing on the subject of impotency to appear up to the 16th century was the Motu Proprio, *Cum Frequenter,* issued on June 27, 1587 by Pope Sixtus V. In this papal announcement, eunuchs and spaded men, who lacked both testicles, were to be considered unfit for marriage by natural law and the Bishops were to have the obligation of impeding marriages which these might attempt to contract or of declaring invalid the unions which these had already entered.

Since the *Cum Frequenter* was destined to play a major role and make such a great contribution to the evolution and development of the understanding of the law on impotency, it would be worthwhile, at this point, to summarize its principal tenets.

The Holy Father declared that eunuchs and spaded individuals, who lacked both testicles, are of a frigid nature, are impotent and are not to be considered apt subjects for contracting marriage; that persons thus afflicted cannot emit *verum semen* but, in their physical relations with women, produce a certain liquid which is similar to *verum semen* but which is not suitable for the generation of children and therefore does not fulfill the purpose of marriage; that these defectives presume to enter marital unions with women, not to live chastely with them as brother and sister but that they might have carnal copula with them under the pretext of a real marriage; that marriages of such persons not only serve no useful purpose, but, on the other hand, afford a definite occasion for sin and scandal and tend to the damnation of the souls of the persons involved; that the marriage of a eunuch would give scandal to his wife, who would realize the unnatural character of the sexual acts performed with him, would give the scandal of temptation to her to seek satisfactory relations elsewhere and be a scandal to others who might know of or suspect his condition.

It is evident from this summary that Pope Sixtus V did not define or describe the term *verum semen* as he probably took it for granted that it would have a definite and precise meaning for the canonists and theologians of that era and that it would be properly understood and interpreted by them. However, the fact that he did not define it accurately or describe it precisely has led to a great deal of confusion in the present day.

The Holy Father did not mention directly or even infer that the *verum semen,* which eunuchs and spaded men could not emit, was manufactured in the testicles and he was careful to avoid stating where it was elaborated or in what it consisted. It would be easy to see, however, why some authors might conclude that the *verum semen* must be a testicular product because, on the one hand, direct reference was made to persons who lacked both testicles and, on the other hand, such persons were considered unfit to contract marriage because they could not emit *verum semen.* Thus, the canonists and theologians could easily fall into the fallacy of "Post hoc, ergo propter hoc" and think that the *verum semen,* which eunuchs and others could not emit, must be manufactured by the testicles, of which they were deprived.

One thing is certain and that is that the understanding of Pope Sixtus V of what constituted *verum semen* and the site of its elaboration was limited by the medical knowledge of the late 16th century which was very meagre at that time. Certainly, the knowledge of the endocrine functions and the field of endrocrinology was little, if at all, appreciated.

It is clear that semen was not thought to be *verum* merely because it contained spermatozoa since these were first discovered ninety years later in 1677 and it was not until 1875 that Oscar Hertwig first demonstrated their function.

Sanchez declared that the *Cum Frequenter* introduced no new doctrine but repeated what had always been held in the natural law, that eunuchs were unable to marry because they could not emit *verum semen* and any marriage, attempted by them, was invalid. Ledesma and Enriquez are quoted by Sanchez as holding the same views.

Apparently, the term *verum semen* was time-honored in theological usage even before the appearance of the *Cum Frequenter*. Sanchez says that the view, demanding it for potency, was the common opinion of theologians and jurists even before the papal pronouncement and mentions that theologians, in their use of the term, refer back to the works of Galen, the Greek physician of the second century. Ferreres confirms this by stating that from the time of Galen and for more than 1300 years before Pope Sixtus V, the distinction between true and false semen was known.

According to Ferreres, *verum semen*, in the sixteenth century, signified the relatively copious and somewhat viscous ejaculate which was produced by a man capable of the marriage act. The distinction between the thin, clear fluid of distillation and the copious more viscous outpouring of pollution was identical with that which is found between true and false semen.

Nowlan, in 1945, states that, in his opinion, the notion of *verum semen*, in the writings of 16th and 17th century theologians, was a convenient designation of the difference between the eunuch and the normal man. They observed that the eunuch was capable of some sort of an ejaculate but it was slight and watery as compared with the greater quantity of thicker substance of the normal man and they rightly concluded that the former was not true semen.

Theologians of the 16th century, as well as the doctors and scientists of the same era, did not understand the physiology of semen production. Otherwise, Enriquez, a competent and capable theologian, would not have speculated on the marriageability of a eunuch who was capable of producing true semen. Since castration not only removes the spermatozoa from the ejaculate but gradually terminates the functioning of the accessory sex glands no one conversant with the true facts, could conceive of a eunuch who was capable of manufacturing *verum semen*.

From the 16th to the 18th centuries, the various authors defined the condition of impotency as the inability of the spouses to become one flesh by the emission of *verum semen* in the vagina. The question of impotency was always discussed in relation to the primary and secondary purposes of marriage; the procreation of offspring and the remedy of concupiscence. The consummation of the marital act was to be the way that these purposes of marriage were to be realized and this consummation required a copulation in which the spouses became one flesh and which was *per se* apt for generation. If the spouses did not become

one flesh with each other or the copulation was not *per se* suitable for the generation of offspring, the relationship was not real consummation and, if these elements were not realized because of the ineptness of the parties, a condition of true impotency was thought to exist. Not any type of intercourse sufficed for the satisfaction of concupiscence but only that which was of its nature apt for the generation of children.

From the above, it is evident that the authors of this period considered a close interrelationship to exist between potency, consummation of a marriage, potential generation of children, a remedy for concupiscence and the becoming one flesh by the parties.

If the marital relationship were to achieve the ends of being apt for the generation of children, even though, *de facto,* children were not born, providing a remedy for concupiscence and causing the parties to become one flesh, a mere joining of the bodies without semination would not be sufficient and *verum semen* would be required for a perfect conjugal copula. Producing, emitting and depositing *verum semen* in the vagina of the wife was considered necessary for generation.

The medical authorities of this period held that eunuchs and spaded men who lacked both testicles were incapable of producing *verum semen* and could not validly marry, because they lacked necessary organs but a man who was deprived of only one testicle could enter a valid marital contract because he could produce *verum semen.*

It is to be observed that, although all the authors mentioned *verum semen* and required it for a perfect conjugal copula, no one of them described or defined it or endeavored in any way to explain or identify it.

In order that man be considered potent and be apt for contracting a valid marriage, he must have a penis that is capable of erection and of penetrating the female vagina and he must be able to produce, emit and deposit *verum semen* within the vagina. The erection must be maintained and sustained until the vagina has been penetrated and until semination has occurred within it.

Zacchias in the eighteenth century, wrote that injuries to the head, spine, lumbar region, inguinal and perineal regions, attrition of the nerve centers, catalepsis, apoplexy and paralysis can interfere with the erection of the penis and so might be causes of male impotency. He also considers cases of hypospadias where the top of the penis was imperforate and instances where the penile aperture was located in the middle or in the base of the organ as possible sources of male impotency.

Other authors discuss, as cause of impotency, the condition whereby a man cannot seminate at all or, if he does emit *verum semen,* he finds it difficult to deposit it within the vagina because of premature ejaculation.

Sanchez and Schmalzgrueber were of the opinion that a man was to be considered potent if he could only deposit part of the semen in the vagina because that

portion would be sufficient to consummate the marriage and effect the union of the two spouses in one flesh.

The theologians and canonists of this period unanimously agreed that old age of and by itself did not constitute an impediment to marriage and did not necessarily cause a man to be impotent. If the elderly man could meet all the above requirements, although it was impossible for him to procreate offspring, because the semen was sterile, he could validly marry. But if the man was so exhausted and debilitated from age that he could not have perfect copula or could not produce *verum semen,* he was to be considered impotent and unable to contract a valid marriage.

The eminent canonist Cardinal Gasparri, made a distinction of great importance between the *human action,* which consists in the act of conjugal intercourse itself and is terminated by the depositing of the *verum semen* in the female vagina, and the *action of nature,* which comprises the function which occurs after the prior action has been completed, whereby the semen is brought into the uterus, advances until it meets an ovum and fertilizes it.

Antonelli, in his classical work on impotency, written in 1900, stated that the important and only purpose for the institution of marriage was to provide for the procreation of children and the propogation of offspring and that spouses became two in one flesh by cooperating in a copula that was ordinated to generation. In order for the spouses to become truly two in one flesh, there should be a uniting towards which each should make a distinct contribution. This would not be possible to attain by the mere joining of the generative organs of each sex, since, in this way, each sex would remain distinct, separate and individual; what is required is for each to give something from which the oneness or unity is made.

The same author continues by saying that male semen is required for proper consummation of a marriage and therefore copula by a eunuch, who lacks both testicles, cannot be said to be *per se* apt for the procreation of children, because the defect is basic, radical and without remedy. The declarations of Pope Sixtus V did not comprise any innovation but were only a repetition of the age-old and honored law, which was in effect before the Pontiff's coronation and which was ultimately and originally based on the natural law. The reason why eunuchs, who lacked both testicles, were estopped from marrying, even though they could effect a penetration, was that they were unable to seminate.

Once again, this author constantly referred to semination, semen, *verum semen,* but refrained from giving any precise description or definition of what these signified.

Antonelli maintained that Pope Sixtus V prohibited marriage for eunuchs precisely because they could not attain the primary end of marriage, even if they could achieve the secondary purpose, because the latter cannot be sepa-

rated from the former, since it is accessory and accidental to the primary objective and came into being only after the sin of Adam and Eve.

This author maintained that it was erroneous to state that a eunuch, lacking both testicles, was not moved by concupiscence. The act of copula, he states, is governed by the nervous system and the appropriate nerve centers are found in the lumbar region. In a man, there are two nerve centers which control his ability to have sexual intercourse: *the center of erection,* which accounts for the erection of the penis and the *center of ejaculation,* which cares for the emission of semen. The eunuch is deficient in the action of the center of ejaculation but is always capable of carnal desire and erection. The cause of the carnal desire is not only the pressure of semen in the seminal vesicles but also all those causes, both physical and psychical, which excite and stimulate the nerves, thereby inducing erection. The eunuch always experiences sexual desire even when with an emission of prostatic fluid and urethral mucous. Sometimes, the concupiscence of a eunuch is more vehement than a normal man and yet, despite this fact, he cannot contract a valid marriage.

According to Antonelli, if the remedy for concupiscence could be attained without reference to generation, Pope Sixtus V never would have declared invalid the marriage of eunuchs, who lacked both testicles, since they have the same, and at times more vehement, concupiscence. The marriage of such were declared invalid not because they could not achieve a satiable copula but because they could not emit *verum semen,* that was apt for generation.

(To be continued)

PLAN EARLY FOR ST. LUKE'S DAY OBSERVANCE . . . .

Preparations for The White Mass, the annual observance to honor St. Luke, Patron of Physicians, on October 18, his Feast Day, will soon be made locally. To give assistance in making plans, the publicity prepared by the Shreveport, Louisiana Guild is indicated here. With an invitation is included the informational brochure concerning the Mass, set forth below.

What is the White Mass?

It is an annual gathering for public worship by those who care for the sick:

—in adoration of the Creator of all life by the men and women who cooperate with God in its preservation here on earth,
—in union with Our Lord Jesus Christ, Healer of bodies as well as Savior of souls, Divine Comforter of the afflicted and the halt and lame,
—under the patronage of St. Luke the Evangelist, himself a physician and for nineteen centuries world-wide model for the medical profession.
—to emphasize the truth of the Spirit in man, who through the sublime instrumentality of parenthood is composed of body and soul, matter and spirit, immortal through the endless ages after death.
—in testimony that we humans are made to the image and likeness of God, made to know Him, love and serve Him that we might become sharers in His Divine Life here and in the eternity to come.

The White Mass, the Memorial Sacrifice of Our Lord's death on the Cross, is likewise offered:

—a group tribute to all in our community who care for the sick,
—that their dedication to their Christ-like vocation may be renewed with the noblest of motives,
—to express our admiration for medical science and its never tiring research to relieve man's suffering,
—in appreciation by mothers and fathers for the devotion and self-sacrifice of doctor, nurse and all others who care for our families and friends in time of crisis and sorrow,
—in token of homage and esteem by our Bishop and clergy as ministers of souls and to you who minister to the body and mind of man's natural life.

PROPOSED PLAN FOR OBSERVANCE OF THE "WHITE MASS"

Arrangements Committee — all members, Catholic

Chairman — President of Guild, with two other members assisting
One Dentist
Two Nurses
Laboratory technician
X-ray technician
Pharmacist
Pharmaceutical detail man
Hospital Administrator
Physio-therapist
One representative from each private nursing registry
Two medical students
Nursing student (one from each training school)
Women's Auxiliary Catholic Hospital and Medical Society, one each
Physician from Veterans' Hospital
Physician from local Army, Navy or Air Force
Chaplain of the Guild

Each member is responsible for informing respective organization of the "White Mass" and of mailing invitations which advise of place, time, and (evening) reception that includes members, Catholic and non-Catholic, and their families. The notice should be published in all the monthly bulletins of the groups and announced at meetings. Secure hospital permission to post an invitation on bulletin board.

Publicity Committee

Secular Press
Diocesan Press
Catholic Church Bulletins

Entertainment Committee

Arrange for refreshments after Mass, served by wives of Guild members.

Ushers Committee

Guild members should form this committee and direct the seating.

Servers Committee

If possible, have Guild members serve the "White Mass."

Speaker's Committee

The Moderator of the Guild should, if possible, offer the Mass.
The Ordinary of the diocese or some outstanding priest speaker should be asked to give the sermon.

Every effort should be made to make this a united offering of the "White Mass" by all men and women "in white" who serve the sick.
If possible, it should be a Dialogue Mass, with the leaflet missal distributed to those attending and following in English, if that is more feasible.
An added touch is for all Guild members to wear a white carnation.
Assign all Guild members to a committee to give them an active part in the observance of the "White Mass."

(INVITATION TO WHITE MASS SPONSORED BY THE SHREVEPORT, LOUISIANA, GUILD)

THE ANNUAL WHITE MASS

FOR ALL MEMBERS OF THE MEDICAL PROFESSION AND ALL OTHERS
DEVOTED TO THE CARE OF THE SICK AND RELATED VOCATIONS
WILL BE OFFERED IN

ST. JOSEPH CATHOLIC CHURCH

CORNER OF FOURTH AND MAIN STREETS

SUNDAY, OCTOBER TWENTIETH, 5:30 P. M.

A RECEPTION WILL FOLLOW IN THE CATHOLIC HIGH GYM

NORTH AND FOURTH

YOU AND YOUR FAMILY ARE CORDIALLY INVITED TO PARTICIPATE

THE CATHOLIC PHYSICIANS' GUILD

MINUTES OF EXECUTIVE BOARD MEETING FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

SIR FRANCIS DRAKE HOTEL SAN FRANCISCO, CALIFORNIA

JUNE 25, 1958

The meeting was called to order by the President, Dr. William J. Egan at 9:45 a. m. Rt. Rev. Msgr. William F. Reilly, Moderator of the Oakland Guild, opened the meeting with prayer.

ROLL CALL

Officers present:

William J. Egan, M.D. — President
Eusebius J. Murphy, M.D. — First Vice-President
Joseph R. Holoubek, M.D. — Second Vice-President
Clement P. Cunningham, M.D. — Third Vice-President

Representatives of Affiliated Guilds present:

Clyde V. Von der Ahe, M.D. — Los Angeles, Calif.
W. Moloney, Sr., M.D. — Los Angeles, Calif.
N. C. Barwasser, M.D. — Rock Island, Ill.
G. Haffner, M.D. — Fort Wayne, Ind.
B. N. Lies, M.D. — Wichita, Kansas
A. F. Rossitto, M.D. — Wichita, Kansas
Very Rev. Bernard E. Vogler — Lafayette, La.
Harold Chastant, M.D. — Lafayette, La.
Anthony Failla, M.D. — New Orleans, La.
Paul Lastropes, M.D. — New Orleans, La.
Alice Holoubek, M.D. — Shreveport, La.
William J. Egan, M.D. — Boston, Mass.
Aubrey J. Pothier, M.D. — New Bedford, Mass.
Geoffrey Brinkman, M.D. — Detroit, Mich.
John P. Kelly, M.D. — Minneapolis, Minn.
John T. Lawton, M.D. — St. Louis, Mo.
Eusebius J. Murphy, M.D. — Bronx, N. Y.
George F. Price, M.D. — Brooklyn, N. Y.
Gerard P. J. Griffin, M.D. — Rockville Centre, N. Y.
Robert M. Eiben, M.D. — Cleveland, Ohio
Jerome Hochwalt, M.D. — Dayton, Ohio
C. R. Roscoe, M.D. — Philadelphia, Pa. (Rene Goupil)
Philip V. Daugherty, M.D. — Nashville, Tenn.
John Comfort, M.D. — Tacoma, Wash.
Oliver F. Bush, M.D. — Dallas, Texas
William J. Fitzgerald, M.D. — Albany, N.Y.
Rt. Rev. Msgr. Thomas A. Markham — Sacramento, Calif.
Frank Darrow, M.D. — Oklahoma City, Okla.

Others:

Rt. Rev. Msgr. William F. Reilly, M.D. — Oakland, Calif.
Rosalie Reardon, M.D. — San Francisco, Calif.
Allen Sterling, M.D. — San Francisco, Calif.
Lawrence Steffen, M.D. — Kansas City, Mo.
Joseph J. Reidy, M.D. — Chevy Chase, Md.

Report of the President

Dr. William Egan welcomed all those attending the meeting, in behalf of the Federation, and thanked them for the spiritual and financial sacrifices they had made to participate in the annual meeting of the Executive Board. All were encouraged to express their views on the topics of the agenda. Dr. Egan advised that his report would coincide with those given for the various committee activities.

THE LINACRE QUARTERLY

In the absence of the Editor, Dr. Egan reported on subscriptions to the Federation's official journal and indicated the following statistics:

June, 1957
—subscriptions totaled 8,540
November, 1957
— subscriptions totaled 8,970
May, 1958
—subscriptions totaled 9,218

The importance of THE LINACRE QUARTERLY was stressed as a publication of reference on medico-moral problems, often quoted by other journals. The president urged the Guilds to encourage members to write articles. Each Guild was asked to appoint an historian whose writing would be a stimulus for other members to submit material for publication in *LQ*. The suggestion became a motion and unanimously passed.

Membership Report

As of the meeting date, there are 75 Catholic Physicians' Guilds affiliated with the national organization. The total number of Guilds in 1950 was 12 and they were located in six dioceses. In June, 1957, there were 61 Guilds, indicating an increase of 14 during the past year. A report from the office of Monsignor McGowan, the Federation Moderator, indicates six new Guilds pending. Word from the St. Louis office of the Federation advises of Guilds pending in Springfield, Mass.; Chicago, Ill.; Duluth, Minn., and Kansas City, Mo.

It was further noted that there are thirteen States that are not represented in the Federation of Catholic Physicians' Guilds, namely: Arkansas, Georgia, Idaho, Maryland, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Utah and West Virginia. A general discussion ensued regarding ways and means of contacting these areas to encourage the formation and development of groups. Three target areas for the present are Maryland, with emphasis on the first diocese in the United States — Baltimore; New Jersey, site of the new Seton Hall Medical School, and Mississippi.

Emphasis was laid on the importance of informing the Guilds of the purposes of the Federation, at the same time maintaining individual autonomy in activities and programs. The benefits derived from membership in the Federation were indicated to be: (1) the opportunity of receiving the official journal; 2) interchanging ideas for activities at the annual and winter meetings of the Executive Board of the Federation; 3) uniting on national projects such as the exhibiting at the A.M.A. convention, a Catholic Action endeavor of great importance, and the "White Mass" on October 18, to honor St. Luke, Patron of Physicians; 4) affords opportunity for a Catholic voice in medicine, on the national level; 5) provides an ideal plane of discussion on which hospital administration and staffs can meet.

Federation Exhibit

Dr. Gerard P. J. Griffin, chairman of the Exhibit Committee, reported excellent response to the Booth at the A.M.A. convention then in progress. Interest on the part of non-Catholic physicians was as great as Catholic members and other Catholic doctors. He stated that the purpose of the project was to supply information through reprints of articles from THE LINACRE QUARTERLY and other publications on medico-moral problems; to increase readership of the official journal of the Federation; to be a good publicity medium to further the Guild movement and membership in the Federation. Dr. Griffin advised that many of the Catholic physicians who visited the booth had not known of Guilds and left enthusiastic about formation of groups in their respective areas. Others were members of local Guilds but unaware of the national organization.

The Exhibit Committee thanked Miss Jean Read, assistant secretary of the Federation, for her efforts in handling the advance details for the setting up of the Exhibit. Gratitude of the Federation is extended to the following whose time and talent were devotedly given to staffing the booth during the days of the A.M.A. convention: Rosalie Reardon, M.D., Clement Cunningham, M.D., George Price, M.D., Eusebius J. Murphy, M.D., William J. Egan, M.D., Paul Wienholz, M.D., Joseph Holoubek, M.D., R. J. O'Laughlin, M.D., S. J. Carnazzo, M.D., Norbert Frey, M.D., Dan Tobin, M.D.,

Frank Darrow, M.D., and Drs. French and Wozniak. Special thanks to the wives who helped — Mrs. Egan, Mrs. Murphy, Mrs. Price and Mrs. Cunningham.

The Exhibit this year also included a basic library of textbooks on medico-moral problems. The one-volume *Medico-Moral Problems* by Father Gerald Kelly, S.J., came off the press in time for display at the convention. A limited number of prominent publishing houses graciously sent us some of their publications for display. It is the wish of the Federation to thank the following for their cooperation: P. J. Kenedy & Sons, New York; Newman Press, Westminster, Md.; McGraw-Hill Book Co., Inc., New York; F. A. Davis Co., Philadelphia, Pa.; Loyola University Press, Chicago, Ill.; Weston College Press, Weston, Mass.; International Catholic Truth Society, Brooklyn, N. Y. Gratitude is extended to Rev. Gerald FitzGibbon, S.J., of Creighton University, Omaha, Neb., for his contribution of many booklets and leaflets concerning spiritual care of patients. The Committee felt that the Federation should again thank Mr. Thomas Mahan, whose generosity provided the display which was first used at the 1956 convention of the A.M.A. in Chicago.

The Chairman also announced to the Board members that the display is available to any local Guild wishing to use it at any appropriate meeting. Shipping and other expenses would, however, be the responsibility of the sponsoring Guild.

Catholic Physician of the Year

In lieu of a definite plan for selecting the Catholic Physician of the Year, the Executive Committee made the choice for 1958. Announcement will be made at the winter Board meeting. Appropriate acknowledgment will be made and a scroll presented at that time.

For future selection of the recipient of this honor bestowed annually, it was suggested that a committee of four or five physicians be named to choose from a list of candidates whose names would be submitted by the respective Guilds. The selection would not be limited to Guild membership, however. It was further recommended that endorsement of the Bishop of the local diocese be obtained before submitting names to the committee.

It was moved that the Guilds be informed of these suggestions and that action be deferred until the winter meeting.

Thomas Linacre Award

The annual Thomas Linacre Award is bestowed on the Catholic physician contributing an article to THE LINACRE QUARTERLY judged by the Editorial Board to be most valuable in content to promote the interests of the journal in its efforts to express opinions in the light of Catholic teaching as applied to medical practice. The Linacre Committee will consider the contributions for 1958 and make the Award at the winter meeting of the Executive Board.

Memorial Mass

The first Memorial Mass for deceased members of Catholic Physicians' Guilds and the medical profession was celebrated on Wednesday morning, June 25, 8:00 a.m. at Notre Dame des Victoires Church, San Francisco. Rev. Flavian Ward, O.F.M., chaplain of St. Joseph's Hospital in San Francisco, was the celebrant.

Dr. Gerard P. J. Griffin of the Rockville Centre Guild and Dr. Eusebius Murphy of the Bronx Guild served the Mass. Dr. Joseph Holoubek, Shreveport Guild; Dr. George Price, Brooklyn Guild; Dr. Frank Darrow, Oklahoma City Guild, and Dr. Clement Cunningham, Rockford, Ill., Guild ushered. Physicians and their families attending the A.M.A. convention were in attendance. Nurses in uniform from St. Mary's Hospital and Mary's Help Hospital and Sisters from the latter hospital also participated.

Plans for the future offering of the Mass will include invitation to all officers and delegates of the A.M.A. requesting their presence and including all deceased members of the Association in the Mass intention. The Bishop of the diocese where the Mass will be offered will be invited to participate.

Winter Meeting

It was voted to hold the winter meeting of the Executive Board in Minneapolis, Minn., December 6-7. The Catholic Physicians' Guild of Minneapolis will be host to the group.

Committee Reports

MEMBERSHIP—Comment was made on the geographic location of the 75 Guilds now affiliated with the Federation. Because some eighteen to twenty-four months often elapse between inquiries to organize Guilds and their actual formation, it was urged that the member groups appoint a local committee to visit areas of their own dioceses, contacting Catholic physicians in an endeavor to organize

more groups; likewise, visits to neighboring dioceses where there are no Guilds was recommended. Contacting the Bishops of the respective dioceses was advised to be the first proecdure to be followed. Chaplains of Newman Clubs and military installations should also be contacted for the formation of new Guilds. At present some 5,000 Catholic physicians belong to Guilds; it was indicated that there are possibly 40,000 Catholic doctors in the United States, representing a great membership potential still ahead.

PROJECTS—It was urged that Guilds sponsor a Memorial Mass at their state level, through the State Medical Society, offering same for deceased members of that group as well as the Guilds.

With the fasting regulations changed, it was recommended that evening Mass be sponsored wherever diocesan permission granted and follow same with supper meetings, in the hope that the later hour might be more convenient.

Also suggested was family type activities to which the wives of members would be invited. A general topic of dual interest would have to be selected for a program.

CONSTITUTION—With one change in wording of Article 6, Section 1, last part to read "Social Action Department of the N.C.W.C." instead of "Administrative Board of Bishops of the N.C.W.C.," the revised Constitution was discussed and will be put to vote for final ratification at the winter meeting of the Executive Board, publication of same having been effected.

WAYS AND MEANS—The financial statement for 1957 and proposed budget for 1958 were presented to the Board for discussion. (Copy of same mailed to all affiliated Guilds.)

It was reported that the sum of $4,163.00 would be mailed to the Treasurer of the Federation, representing surplus from the Jubilee celebration held in New York City on June 5, 1957.

New Business

It was moved that the Federation appoint Mr. Thomas Mahan an honorary advisor to the Federation, in acknowledgment of his outstanding contributions to the advancement of Catholic Action in behalf of the Federation. Motion passed.

An insurance plan was presented that would enable the Federation to carry out plans for a Scholarship Fund. It was voted to discuss the matter further at the winter meeting of the Executive Board.

The President asked that the Federation acknowledge, with thanks, contributions by Mr. Tom Casey of the Tampax Corporation and the Merck, Sharpe & Dohme Corporation for the reception which followed the Board meeting.

The Board, wishing to express appreciation to Reverend John J. Flanagan, S.J., Executive Director of The Catholic Hospital Association, for his years of guidance and interest in the Federation, voted a gift of expenses and $500.00 for a European voyage, during the hospital and medical meetings in Brussels, July, 1958.

Meeting adjourned — 1:00 p. m.

Reception, Sir Francis Drake Hotel, 4 until 6 p. m. for Catholic physicians and families attending the A.M.A. convention.

Book Review

Artificial Insemination in the Human

A. M. C. M. Schellen, M.D.
(Translated by Miss M. E. Hollander)

Review by
GERALD KELLY, S.J.

This book defies reviewing, in the strict sense of the word. It is encyclopedic in scope—covering practically every conceivable aspect of artificial insemination, and covering each aspect thoroughly. It gives the history of the artificial-insemination movement, all the needed definitions, the methods of examination, the methods of effecting insemination, public opinion and laws in various countries, and the religious, moral, and professional views on the practice. Dr. Schellen has not only visited various countries in order to know the practical and clinical problems and solutions; he has also covered a vast range of literature and thoroughly digested it. Readers of THE LINACRE QUARTERLY will be pleased to note that many of its articles are included in his citations and have had a definite influence on his conclusions.

The author is very firmly opposed to insemination of an unmarried woman. This, he says, "is nothing but a monstrosity." And, for a variety of reasons that are well explained and well defended, he opposes donor insemination of a married woman. His attitude on homologous insemination is not so clearly expressed; but one can safely say, at the minimum, that he is not enthusiastic about it. The general impression I gather from the book is that his conclusions would be very much the same as those that have been expressed more than once in these pages.

Anyone who is interested in the topic of artificial insemination should read Doctor Schellen's book. It is a truly monumental work.

Artificial Insemination in the Human
Published by
Elsevier Press., Inc. (Houston 2, Texas)
Bank of the Southwest Building
XIII 420 pages
$14.00

Roll Call

CATHOLIC PHYSICIANS' GUILDS

The listing below gives the name of the president and moderator of each Catholic Physicians' Guild affiliated with the Federation. These groups constitute the national organization.

ALABAMA

Mobile

President	*Moderator*
Charles D. Terry, M.D. 726 Fulton Avenue	Rev. P. H. Yancey, S.J.

ARIZONA

Phoenix

Victor A. Mulligan, M.D. 5340 North Central Avenue	Rev. John P. Doran

CALIFORNIA

Los Angeles

Thomas E. Havel, M.D. 1328 - 22nd Street Santa Monica	Rt. Rev. Msgr. J. J. Truxaw

Sacramento

Arthur F. Wallace, M.D. Forum Building	Rt. Rev. Msgr. Thomas Markham

COLORADO

Denver

Thomas H. Foley, M.D. 1934 E. 18th Avenue	Very Rev. Msgr. David Maloney

CONNECTICUT

New Haven

David Conway, M.D. 1427 Chapel St.	Rev. John C. Knott

Norwich

John Caruso, M.D. 293 Montauk Avenue New London	Rt. Rev. Msgr. John J. Reilly, V.G.

Stamford

Victor Mulaire, M.D. 22 Sound Avenue	Rt. Rev. Msgr. N. P. Coleman

DELAWARE

Wilmington

John G. Graff, M.D. 1407 Woodlawn	Rev. Eugene Clarahan

ILLINOIS

Belleville

Matthew B. Eisele, M.D. 632 Alhambra Court E. St. Louis	Rev. Clement G. Schindler

Rock Island

F. E. Bollaert, M.D. 1300 18th Avenue E. Moline	Rev. John O'Connor

INDIANA

Evansville

Douglas Giorgio, M.D. St. Mary's Hospital	Rt. Rev. Msgr. Thos. J. Clark

Fort Wayne

Carroll O'Rourke, M.D. 604 W. Berry Street	Rev. Albert Senn, O.F.M.

Hammond

John Nicosia, M. D. 701 Main St. E. Chicago, Indiana	Rev. Robert Emmons

IOWA

Davenport

Roscoe P. Carney, M.D. 2502 Iowa Street	Rev. John P. Dolan

Dubuque

Thomas F. Thornton, Jr., M.D. 505 Black Building Waterloo	Rt. Rev. Msgr. T. J. Gannon

Sioux City

Raymond J. Duling, M.D. 937 Badgerow Bldg.	Very Rev. Msgr. W. B. Bauer

KANSAS

Wichita

B. N. Lies, M.D. Colwich, Kansas	Rev. Patrick J. Holloran, S.J.

KENTUCKY

Louisville

J. Randolph Buskirk, M.D. 1329 Story Ave.	Rev. Bernard Boone

LOUISIANA

Alexandria

R. E. C. Miller, M.D. 830 Desoto Street	Rev. Paul E. Conway

Baton Rouge

Ben F. Thompson, M.D. 3347 Government Street	Rt. Rev. Msgr. H. P. Lohmann, V.P.

Lafayette

E. P. Breaux, M.D. 1308 Myrtle Place	Very Rev. Bernard Vogler

New Orleans

Warren Hebert, M.D. 1521 Washington Ave.	Very Rev. T. U. Bolduc, S.M.

Shreveport

Frank F. Marsh, M.D. 736 Elmwood St.	Rev. Marvin J. Bordelon

Southwest Louisiana
(Lake Charles)

Andrew Ranier, M.D. St. Patrick's Hospital Lake Charles, La.	Rt. Rev. Msgr. L. H. Boudreaux, S.T.D.

MAINE

Portland

Francis M. Dooley, M.D. 53 Deering Street	Rev. Thomas M. Lee

MASSACHUSETTS	
Boston John P. Rattigan, M.D. 247 Commonwealth Ave.	Rev. Michael Walsh, S.J.
Fall River Francis J. D'Errico, M.D. 130 Rock Street	Rev. Daniel F. Shalloo
New Bedford Arthur Buckley, M.D. 319 A. Union Street	Very Rev. H. A. Gallagher
Pittsfield Antonio Massimiano, M.D. 231 William St.	Rev. Francis E. Hilbert
MICHIGAN	
Detroit E. G. Nedwicki, M.D. 21920 W. Outer Drive Dearborn 8, Mich.	Rev. Kenneth MacKinnon
Grand Rapids Arthur Tesseine, M.D. 1328 Madison Avenue, S.E.	Rt. Rev. Msgr. Raymond Sweeney
Saginaw Thomas V. Kretschmer, M.D. 305 Wiechmann Bldg.	Rev. Francis A. Jurek
MINNESOTA	
Minneapolis F. J. MacCaffrey, M.D. 407 Medical Arts Bldg.	Rev. George Garrelts
St. Cloud W. Skaife, M.D. 117 S. 14th Street Benson, Minn.	Rev. Patrick Riley
MISSOURI	
St. Louis Robert F. Hickey, M.D. Missouri Theatre Bldg.	Rt. Rev. Msgr. C. B. Faris
MONTANA	
Great Falls Robert J. McGregor, M.D. 301-21 Ford Building	Rt. Rev. Msgr. James J. Donovan
NEBRASKA	
Omaha Frank D. Donahue, M.D. 273 Aquila Court	Rev. Austin Miller, S.J.
NEW YORK	
Albany Clement J. Handron, M.D. 115 Third St. Troy, New York	Rev. Edward L. O'Malley
Bronx Daniel J. McAuliffe, M.D. 300 E. Tremont Avenue New York 57, N. Y.	Rev. Ignatius W. Cox, S.J.
Brooklyn George F. Price, M.D. 66 Rutland Road	Rev. James H. Fitzpatrick
Buffalo Carroll Keating, M.D. 2844 Main Street	Rev. Michael Sekelsky

Rockville Centre	
Jeff J. Coletti, M.D. 30 Guinea Woods Road Old Westbury, L. I., New York	Rev. Thomas McGlade
New York	
John L. Madden, M.D. 123 E. 69th St.	Rev. James J. Rohan, S.J.
Queens County	
Edward J. Doherty, M.D. 8720 96th Street Woodhaven 21, New York	Rev. James H. Fitzpatrick
Rochester	
William L. Madden, M.D. 296 So. Goodman St.	Rt. Rev. Msgr. Arthur E. Ratigan
Staten Island	
John J. Sibley, M.D. 780 Forest Ave.	Rev. Joseph J. Riordan
Utica	
Stephen C. F. Mahady, M.D. Broadacres Sanatorium	Rev. Daniel E. Lawler
Westchester	
William P. Clark, M.D. 145 Prospect Ave. Mt. Vernon, New York	Rev. John Goodwine
OHIO	
Canton	
James J. Karam, M.D. 846 Mahoning Rd., N. E.	Rev. Henry M. Gallagher
Cleveland	
Thomas R. Nolan, M.D. 618 Osborn Medical Building	Very Rev. Msgr. Francis Carney
Dayton	
John M. Roll, M.D. 116 Squirrel Road	Rev. Edwin M. Leimkuhler, S.M.
Youngstown	
D. Edward Pichette, M.D. 1005 Belmont Ave., Room 320	Rev. Joseph Lucas
OKLAHOMA	
Oklahoma City	
Leo J. Starry, M.D. 1200 N. Walker	Rt. Rev. Msgr. Gilbert Hardesty
OREGON	
Eugene	
William H. Gaughan, M.D. Medical Center Bldg.	Very Rev. Edmund J. Murnane
Portland	
Joseph T. Hart, M.D. 6201 S. W. Capitol Highway	Rev. Ludovic J. Derouin
PENNSYLVANIA	
Philadelphia	
(St. Rene Goupil Guild) Joseph J. Toland, Jr., M.D. 1241 W. Lehigh Ave.	Rev. Laurence Maher
(St. Francis of Assisi Guild) Thomas J. English, M.D. 1707 Ritner St. Joseph M. Gambescia, M.D. 255 So. 17th St.	Rev. Nelson J. Curran

Pittsburgh	
William F. Brennan, M.D. Jenkins Arcade	Very Rev. Msgr. Joseph G. Findlan
SOUTH DAKOTA	
Sioux Falls	
William E. Donahoe, M.D. 1600 S. Western	Rev. James Joyce
TENNESSEE	
Knoxville	
Robert Brimi, M.D. 304 Medical Arts Bldg.	Rev. Leo C. Baldinger
Nashville	
Philip V. Daugherty, M.D. 5205 Charlotte Ave.	Rev. James D. Niedergeses
TEXAS	
Dallas	
O. F. Bush, M.D. 3707 Gaston	Rev. Lawrence de Falco
El Paso	
Clement Boehler, M.D. 3015 Silver Street	Rt. Rev. Msgr. Hugh G. Quinn
Houston	
J. Winston Morrison, M.D. 4528 Griggs Road	Very Rev. Victor B. Brezik
San Antonio	
William J. Block, M.D. 407 Elizabeth	Rev. Thomas French
VERMONT	
Burlington	
Maurice J. Walsh, M.D. 216 So. Union St.	Rev. Donald H. Byrnes
VIRGINIA	
Arlington	
Desmond O'Doherty, M.D. 3800 Reservoir Road, N. W. Washington, D. C.	Rev. John J. McMahon
WASHINGTON	
Tacoma	
A. P. O'Leary, M.D. Medical Arts Bldg.	Rev. Charles E. Kelly
WISCONSIN	
La Crosse	
Howard L. Barton, D.D.S. La Crescent, Minn.	Rev. Norman R. Senski
Milwaukee	
Donald T. Hughson, M.D. 2035 Two Tree Lane	Rev. Francis J. Bisenius
WYOMING	
North-Central Wyoming (Sheridan)	
Jack R. Rhodes, M.D. 603 So. Main St. Sheridan, Wyoming	Rev. Philip Colibraro
PUERTO RICO	
Santurce	
Ramon M. Suarez, M.D. Clinica Mimiya Santurce, Puerto Rico	Rev. Donato Cavero, S.J.
CANADA	
British Columbia (Vancouver)	
Harry Pitts, Jr., M.D. 1691 Somerset Cres.	Rev. J. A. Leahy, S.J.